

THE LONDON LETTER

GENERAL PRACTITIONERS AND THE N.H.S.

Some important decisions about matters governing the relationship between general practitioners and the National Health Service were taken when the representatives of the local Medical Committees met for their Annual Conference in London on June 6 and 7. This incidentally was the Conference addressed by the Minister of Health, when he made his speech refuting allegations that any significant emigration of British doctors was taking place, as reported in a previous London Letter. There were two major financial decisions before the House, and one related to the vexed question of merit awards for certain general practitioners in the N.H.S. Probably all Canadian readers are familiar with the fact that certain consultants or specialists in the Service are given additional money because of their talents or experience, and that such awards are not made public. At the last Conference in 1960 the representatives of general practitioners had accepted by a narrow majority the principle of differential payments to general practitioners, but they now reversed that decision by 99 votes to 70 after a long and impassioned debate. The proposal of a working party representing Government and the profession had been to select up to 1000 doctors out of the general practitioner pool for payments of not less than \$1500 dollars a year, mainly on the basis of recommendations of local assessors drawn from various branches of the profession. The proposal was lost mainly on the grounds that it would be impossible to select general practitioners for these awards. The global sum of one and a half million dollars which would have been available to the profession is therefore rejected with contempt, and in addition the unfortunate Committee which has laboured during the past year to produce a scheme for the distribution of the money has done all its work in vain.

The Conference did not reject another sum of approximately three million dollars which is to be earmarked for schemes intended to make the best possible general medical service available to the public. One of the obvious targets for the scheme was postgraduate education, and one-quarter of this sum is to be used in establishing a postgraduate education fund. It has also been suggested that the rest of the money be used to make an extra loading payment to general practitioners for those 500 patients which bring his list from 1000 to 1500. The idea is to encourage the medium-sized practice and discourage the very large list.

Another financial aspect of general practice which was given some necessary thought is the iniquitous scheme in the N.H.S. whereby extra earnings of general practitioners in the Service from work done in hospitals or for local authorities is paid for by taking it out of a central pool out of which all capitation fees for patients are paid. Thus, for example, when there were recent smallpox outbreaks in Britain, thousands of patients were vaccinated by general practitioners, but the payments for vaccination simply came out of the pool and reduced the practitioners' other earnings. The Conference felt that any extra remunerations to general practitioners for services rendered outside the framework of ordinary general practice should be pro-

vided from a different fund, and there would certainly seem to be adequate justification for this. The reports declared that the present relative average remuneration of general practitioners under the N.H.S. is so low as to endanger the future of general practice, and also passed a motion that in view of the continually increasing content of medical service, means should be found to reduce the maximum size of G.P. lists without loss of income. Those medical economists who are rigidly opposed to the capitation system of payment will observe from the above that the Conference was in effect protesting against this system.

DIETARY FATS AND THE BLOOD

For some years now a group of Toronto workers, of whom the best known is Dr. J. F. Mustard, have been investigating the relationship between dietary fats and certain blood factors including clotting. Their studies, many of which have been published in the *Canadian Medical Association Journal*, suggest that blood clotting as measured by *in vitro* tests is accelerated during alimentary lipemia, and their latest paper (*Brit. Med. J.*, 1: 1651, 1962) refers to work designed to show whether previous results are also obtainable *in vivo*. They studied blood coagulation, platelet survival and turnover, and blood lipids in a group of seven patients maintained successively on one of three rigidly controlled diets for a period of several weeks. The subjects were male veterans at Sunnybrook Hospital, Toronto, aged 56 to 65 years, in most cases with a previous history of complications of atherosclerosis. They gave three of the patients the following diets in succession: (1) a low-fat diet; (2) a diet rich in egg yolk and dairy fat; and (3) a diet without dairy produce and with most of the fat from vegetable sources. The other four patients had the same diets but in the reverse order. Results showed that the coagulant activity of the blood was greatest when the subjects were given the egg and dairy-fat diet, and that platelet half-life was shortest and turnover greatest during the same period, while the platelet half-life was significantly longer on the low-fat diet. The highest mean cholesterol and phospholipid values were found during the period of egg and dairy-fat diet.

It is worth noting that there were no significant differences as regards blood clotting between the effects of the low-fat and the vegetable-fat diets. The main difference between the vegetable-fat and the dairy-fat diets seems to lie in the lipid content, and it is known that dairy-fat and eggs contain a coagulant-active lipid not present in corn oil, but the exact factors in the diet responsible for differences found in the present study have not been clearly identified. The authors emphasize the important point that dietary factors known to raise blood cholesterol also accelerate blood clotting, and they point out that the changes in platelet economy they were able to produce by varying diet were as great as those achieved with intensive anticoagulant therapy. They suggest that dietary management might on a long-term basis be more effective for patients with atherosclerosis and its complications than anticoagulants.

A SPECIALIST IN RARE DISEASES

One of the many interesting figures in British medicine passed away on June 2, having failed by 11 months to complete his century. During the 99 years of his life, Dr. Frederick Parkes Weber had distinguished himself by his unique knowledge of rare disorders and syndromes, and indeed his name was associated with no less than four diseases. Thus he shared with Rendu and Osler (who had a high opinion of his scholarship) in the title of Rendu-Osler-Weber disease or familial telangiectasis, and his name appears also in Weber-Christian disease or nodular panniculitis, in Sturge-Weber disease or cerebral angioma with facial nevi, and lastly Weber's disease or localized epidermolysis bullosa. He was the first to describe arteritis obliterans of the legs, which he did in 1908 before the publication of Buerger's paper, and he reported cases of hypertrophy of the limbs associated

with hemangiectasis, sometimes referred to as the Weber-Klippel syndrome. This remarkable man continued to attend clinical meetings in London until a few years before his death, and his fantastic knowledge of rare disease was often drawn upon to resolve an obscure diagnosis. He studied his medicine in London, qualifying in 1889, and his chief appointment was as Honorary Physician to the German Hospital in London, on whose staff he seems to have served from 1894 to the present year, though he probably did little for them after the first 50 years of service. Apart from rare diseases, Parkes Weber was a tremendous collector of coins, medals and antique vases, and his collection has mostly been dispersed to such places as the British Museum, the Boston Medical Library, and the Bodleian in Oxford. He published enormous numbers of case reports and his notes on rare diseases are still being published by H. K. Lewis of London, the series having now reached No. 12.

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MEDICAL NEWS IN BRIEF

PULMONARY DIFFUSING CAPACITY IN CIGARETTE SMOKERS

A study undertaken by Matt (*Ann. Intern. Med.*, 56: 39, 1962) shows that the carbon monoxide pulmonary diffusing capacity is significantly impaired in heavy smokers as compared with non-smokers. This occurs to a slight degree after the first five years of smoking and increases markedly after 10 years. Evidence suggests that this mild form of alveolo-capillary block may be reversible. The mechanism of impairment of pulmonary diffusing capacity is not understood. It is suggested, however, that anatomical alterations in the alveolar septum secondary to the irritating effects of the tobacco smoke are the probable cause of this impairment.

CIGARETTE SMOKING AND CORONARY HEART DISEASE

While the importance of cigarette smoking in the pathogenesis of cancer of the lung is still widely discussed, it is becoming clear that the same habit is related to mortality in general, and to death from coronary disease in particular. Two American studies support this opinion, and these have recently been reviewed together by Doyle *et al.* (*New Engl. J. Med.*, 266: 796, 1962).

The studies in question are the now well-known prospective enquiries at Albany and Framingham, each involving about 2000 men of middle age who were followed up for six and eight years, respectively.

In both studies cigarette smoking was found to be associated with a mortality rate from all causes significantly higher than that of non-smokers. The excess mortality was due largely to coronary heart disease; yet not entirely so, as there is evidence that cigarettes have some other lethal effect not yet elucidated. It would appear that tobacco does not cause angina pectoris as commonly as clinicians have supposed.

It is interesting (and has in fact been commented upon before) that the risk to cigarette smokers is not shared by smokers of pipes or cigars, or by those who formerly had smoked cigarettes but have given up the habit. Whatever the mechanism may be, these studies suggest that, as one smokes cigarettes for longer periods of time or more heavily, so the hazard of coronary heart disease is increased.

CRYPTOCOCCAL INFECTION FOLLOWING STEROID THERAPY

Cryptococcal infection occurred in a 49-year-old woman who had been under treatment with steroids for rheumatoid arthritis for a period of nine years. Certain features of the case suggested that susceptibility to a mycotic infection was promoted by the steroid. Goldstein and Rambo (*Ann. Intern. Med.*, 56: 114, 1962) report a review of the English literature on this subject covering the years 1950-1960, which was carried out to determine if the therapeutic use of steroids increases general susceptibility to cryptococcal infections. Among the reported cases of cryptococcosis, 147 were sufficiently documented from the clinical point of view to permit their inclusion in the analysis. Of these, 8 (5.4%) occurred during or immediately after steroid therapy. In three of these eight, clinical observations provided strong evidence that the administration of steroids had increased the patient's susceptibility to cryptococcal infections. Among the cases of cryptococcosis included in the analysis, 9.5% occurred in patients with reticuloendothelial malignancies. This rather poorly defined group was the only one in which the incidence of cryptococcal infection was higher than that in patients treated with steroids. From these data, the authors conclude that the therapeutic use of steroids may increase the susceptibility to cryptococcal infection.

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